

Premier Health Networks of Alabama



Preferred Provider Network

PLEASE TYPE OR USE BALL POINT
PEN SHADED AREAS FOR
PREMIER USE ONLY

TERMS OF PARTICIPAION, FORM
CODE HOSPITAL/

GOVERNING LAW STATE OF

I/We hereby apply for preferred provider status in Premier Health Networks of Alabama. I/We certify that the information provided on this form and the Premier Health Networks of Alabama Provider Application is accurate to the best of my/our knowledge and belief. If this application is accepted by Premier Health Networks of Alabama, I/we acknowledge that I/we have read the Terms of Participation, and agree to abide by such Terms of Participation.

PROVIDER/PHYSICIAN GROUPS

If this application is being submitted on behalf of a legal entity representing two or more physicians, the Physician Application should be completed for **each participating physician** and submitted with this application.

IF PROVIDER/PHYSICIAN GROUP

NAME OF CORPORATION OR OTHER LEGAL ENTITY (PRINT)

NAME OF AUTHORIZED REPRESENTATIVE (PRINT)

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

IF INDIVIDUAL PROVIDER/PHYSICIAN

NAME

SIGNATURE

DATE

ACCEPTED AND AGREED TO

Premier Health Networks of Alabama

NAME (PRINT)

TITLE

SIGNATURE

EFFECTIVE DATE OF AGREEMENT

ANNIVERSARY DATE OF AGREEMENT